CENTERS FOR MEDICARE & MEDICAID SERVICES 45th 3/22/14 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445491	A. BUILDING _____ B. WING _____	02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKENDREE VILLAGE INC	4347 LEBANON ROAD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a Significant Change of Status Minimum Data Set (MDS) for a change in condition of one resident (#36) of twenty-three residents reviewed. The findings included: Resident #36 was admitted to the facility on November 12, 2013, with diagnoses including Esophageal Reflux, Dementia, Anemia, and Joint Replacement Knee. Medical record review of the Admission Evaluation and Interim Care Plan dated November 12, 2014, revealed at the time of admission the resident was at risk for the development of pressure ulcers.	F 274	Allegation of Substantial Compliance McKendree Village (herein after referred to as "facility") has and continues to be in substantial compliance with 42 CFR Part 482.13, Requirements for Long Term Care Facilities. McKendree Village has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein. This Plan of Correction constitutes McKendree Village's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before March 22, 2014. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with 42 CFR Part 482.13, Requirements for Long Term Care Facilities, McKendree Village has taken or will take the actions set forth in this plan of correction. **F 274 483.20(b) (ii) COMPREHENSIVE ASSESSMENT AFTER A SIGNIFICANT CHANGE** The facility has and will continue to conduct a comprehensive assessment of a resident within 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition.	3/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Barbara Morrison Executive Director 2/20/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	Continued From page 1 Medical record review of the Weekly Skin Integrity Review dated December 4, 2013, revealed the resident had developed one pressure ulcer on the right heel and one pressure ulcer on the left heel. Medical record review of a Telephone Order dated January 2, 2014, revealed "...(change) POST (Physicians Orders for Scope of Treatment) form to DNR (Do Not Resuscitate) (with) no Antibiotics. Comfort Measures Only. No further infection related testing ..." Medical Record review of the Admission MDS (Minimum Data Set) with Assessment Reference date of November 26, 2013, indicated the resident did not have any pressure ulcers and did not indicate any decline in the resident's condition. Interview with MDS Coordinator #1 on February 4, 2014, at 2:40 p.m., in the computer room confirmed a significant change of status MDS had not been completed to reflect the pressure ulcers or to reflect the decline in the resident's condition.	F 274	On or before March 22, 2014, the Health Center Minimum Data Set (MDS) Coordinators, Licensed Social Workers, Dietitian and the Activity Director will attend an in-service. The in-service will be conducted by the Director of Nursing or Designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Conditions/changes in a residents status that trigger a significant change assessment • Completing a significant change assessment Resident # 36 has and continues to receive all necessary care and services. Resident #36 has been reassessed and a significant change Minimum Data Set assessment has been completed. The MDS assessments of residents who have had an MDS assessment competed on or after January 1, 2014 have been reviewed to ensure a significant change assessment was completed if indicated. Beginning March 14, 2014 the Administrator or designee will monitor for continued compliance through Quality Improvement audits.(See Attachment A).The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: March 22, 2014	3/22/14
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	**F 314 483.25 (C) TREATMENT / SERVICES TO PREVENT / HEAL PRESSURE ULCERS** The facility has and will continue to ensure that a resident having pressure ulcers receives the necessary treatment and service to promote healing, prevent infection and prevent new ulcers from developing. On or before March 22, 2014, Health Center Licensed Nurses and Certified Nurse Aides will attend an in-service. The in-service will be conducted by the Director of Nursing or	3/22/14

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F 314	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a pressure relieving device was in place for one resident (#36) of two residents reviewed for pressure ulcers of twenty-three residents reviewed. The findings included: Resident #36 was admitted to the facility on November 12, 2013, with diagnoses including Esophageal Reflux, Dementia, Anemia, and Joint Replacement Knee. Medical record review of the Weekly Skin Integrity Review dated February 4, 2014, revealed one pressure ulcer on the right heel and one pressure ulcer on the left heel of resident #36. Continued review of the Weekly Skin Integrity Review revealed "...Skin Condition...eschar (dead tissue) heels..." Medical record review of a Telephone Order dated December 4, 2014, revealed "...Waffle Boots at all times..." Observation of the resident on February 4, 2014, at 1:20 p.m., in the resident's room revealed the resident lying in bed with the right and left heel lying on the mattress without Waffle Boots in place. Interview with Registered Nurse #1, at the time of the observation confirmed the resident did not have the Waffle Boots in place.	F 314	Designee, and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Use of pressure relieving devices to prevent or treat pressure ulcers Resident # 36 has and continues to have pressure relieving devices in place per physician's order. Other residents with a pressure ulcer have been observed to ensure pressure relieving devices are in place per physician's order. Beginning March 14, 2014, the Administrator or designee will monitor for continued compliance through Quality Improvement audits (See Attachment A) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: March 22, 2014	3/22/14

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F 323 F 323 SS=D	Continued From page 3 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide supervision to prevent falls for one (#28) resident of three residents reviewed for accidents of twenty-three residents reviewed. The findings included: Resident #28 was admitted to the facility on November 11, 2013, with diagnoses including Altered Mental Status, Urinary Tract Infection, and Falls. Medical record review of the Admission Minimum Data Set (MDS) dated November 18, 2013, revealed the resident had severe impairment in cognitive skills, required extensive assistance with two persons for toilet use, and was only able to stabilize with human assistance moving on and off of the toilet. Medical record review of a Fall Risk Assessment dated November 23, 2013, revealed the resident was at risk for falls.	F 323 F 323	**F 323 483.25(h) FREE OF ACCIDENTS/ HAZARDS/ SUPERVISION /DEVICES** The facility has and will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents On or before March 22, 2014, Health Center Licensed Nurses and Certified Nurse Aides will attend an in-service. The in-service will be conducted by the Director of Nursing or Designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Providing assistance during toileting according to resident needs Resident # #28 no longer resides in the facility. Random observations of residents who require assistance with toileting and who have a history of falls since January 1, 2014 are being conducted to ensure residents receive assistance as needed. Beginning March 22, 2014, The Administrator or designee will monitor for continued compliance through Quality Improvement audits (See Attachment A) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: March 22, 2014	3/22/14

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F 323	Continued From page 4 Medical record review of a Nurse's Note dated December 20, 2013, revealed "called to Residents bathroom...by a tech. Tech was transferring resident to the toilet and states resident became weak and...leaned (resident) against...body and slid (resident) to the floor...no signs of injury noted..." Medical record review of a Nurse's Note dated January 30, 2014, revealed "...resident was observed sitting on the floor of...bathroom when Certified Nursing Assistant (CNA) answered (resident's) light, (resident) had attempted to toilet...(no injury)." Observation on February 4, 2014, at 1:30 p.m., revealed the resident seated in a wheelchair in the resident's room. Interview with the Director of Nursing (DON), on February 4, 2014, at 3:10 p.m., in the conference room confirmed the resident was to have two person assistance for transfers at the time of the fall on December 20, 2013. Interview with CNA #1 (CNA who found the resident on the floor on January 30, 2014) on February 5, 2014, at 10:25 a.m., confirmed the nurse had assisted the resident on the toilet, when the resident put the call light on "I went in and found (the resident alone) on the floor." Interview with the DON, on February 5, 2014, at 10:30 a.m. in the conference room confirmed the resident was not to be left alone in the bathroom at the time of the fall on January 30, 2014.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 5 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store food under sanitary conditions and failed to maintain a clean and sanitary kitchen. The findings included: Observation with the Dietary Manager on February 3, 2014, at 8:15 a.m., in the kitchen revealed: 1. The preparation table had food particles and debris at the back of the table after the table had been cleaned in preparation for the lunch meal. 2. A square container on the preparation table with cooking utensils stored ready for use, had food particles and liquid on the inside bottom in contact with the cooking utensils. 3. Five of five 18x8 pans ready for use had liquid, food particles and a greasy substance on the inside and outside of the pans. 4. A container in the reach in refrigerator containing a red sauce (kind unknown) ready for use, with an expiration date of January 21, 2014. Continued observation with the Dietary Manager	F 371	**F 371 483.35(I) FOOD PROCURE, STORE/ PREPARE/ SERVE** The facility has and will continue to ensure that food is procured from sources approved or considered satisfactory by Federal, State or local authorities and that food is stored, prepared, distributed and served under sanitary conditions. On or before March 22, 2014, Health Center Dietary staff will attend an in-service. The in-service will be conducted by the Executive Chef or Designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Cleaning food prep surfaces • Cleaning containers for storing utensils • Cleaning pots and pans • Labeling, covering and dating items placed in the walk in cooler and reach in refrigerator • Discarding items not used by the expiration date The preparation table is clean and free of food particles and debris. The square container on the preparation table with cooking utensils is clean and free of food particles.	3/22/14

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F 371	Continued From page 6 in the walk in cooler revealed: 1. Five trays of fruit stored uncovered and no date. 2. Two covered carts containing assorted desserts not dated on the cover, trays or containers. 3. One covered cart with six trays of assorted juices with a date of January 30, 2014 on the plastic cover. Interview with the Dietary Manager at the time of the observation confirmed the food was not stored properly and the kitchen was not clean or sanitary. Observation on February 4, 2014 at 9:20 a.m., with the Dietary Executive Chef in the kitchen revealed: 1. Twelve of twelve four inch deep long half pans with black crusty substance on the bottoms, sides and corners with the pans stacked inside of each other ready for use. 2. Twenty-two of twenty-two sheet pans stored and ready for use had black thick crusty debris on the bottoms sides and corners. Interview with the Dietary Executive Chef at the time of the observation confirmed the kitchen was not clean and sanitary.	F 371	The 18X8 pans are clean and free of any greasy substance. The red sauce with the expiration date of January 21, 20914 was immediately discarded. Food in the walk in cooler is covered, labeled and dated as required. The juices dated January 30, 2014 were immediately discarded. The four inch pans are clean and free of crusty debris. The sheet pans are clean and free of crusty debris. Beginning March 14, 2014 the Administrator or designee will monitor for continued compliance through Quality Improvement audits (See Attachment B) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: March 22, 2014	3/22/14
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372	**F 372 483.35(i) (3) DISPOSE GARBAGE OR REFUSE PROPERLY** The facility has and will continue to dispose of garbage and refuse properly.	3/22/14

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F 372	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure garbage and refuse was properly disposed of. The findings included: Observation on February 4, 2014, at 9:50 a.m., with the Dietary Executive Chef and the Administrator, at the dumpsters behind the kitchen revealed three dumpsters with a large amount of refuse including uneaten food, empty beverage containers, empty food containers, and an unidentified brownish red substance inside of a plastic covering the ground surrounding the dumpsters. Interview with the Dietary Executive Chef at the time of the observation confirmed the facility had failed to ensure the garbage and refuse was disposed of properly.	F 372	On or before March 22, 2014 Health Center, Dietary staff will attend an in-service. The in-service will be conducted by the Executive Chef or Designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Disposal of refuse; keeping area around the dumpsters free of refuse The area in and around the dumpster is free of refuse. Beginning March 14, 2014 the Administrator or designee will monitor for continued compliance through Quality Improvement audits (See Attachment B) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: March 22, 2014	3/22/14